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GOVERNOR BACON HEALTH CENTER

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On January 30th, 1947, the Fort du Pont Reservation was transferred to the state of Delaware in the presence of the members of the state legislature, state officials, members of the medical profession and many others, representing the various groups of our state.

His Excellency, Governor Walter W. Bacon, in accepting the property said, "I predict that within a few years, the benefits derived from this project will rank with those of our original school and road building program, and the building of our new Delaware River Bridge. This project furnishes buildings and grounds which will give our state an ideal set-up and bring many benefits and opportunities, denied at present, not only in our own state, but in many other communities.

"It is most gratifying to know that we are transforming a plant, designed entirely for war purposes, to one beneficial to the health, happiness, and welfare of our state, and a place, where many may be rehabilitated into useful citizens."

The deed was transferred to the state of Delaware with a definite provision, that the reservation be utilized for a period of twenty-five years, for the care and treatment of emotionally handicapped and crippled children, children awaiting assignment to foster homes, certain children awaiting trial in the family and juvenile courts, alcoholics without psychosis, epilepties without psychosis, terminal senile cases, an emergency hospital unit, and many other related health and welfare problems. It also provides that the veterans of both wars and their families will have priority to the services rendered by the Center.

In April, 1947, the state legislature passed appropriate bills, (Senate bills No. 158, No. 225 and House Bill No. 140) transferring the Fort du Pont Reservation to the State Board of Trustees of the Delaware State Hospital, with provision to establish the Governor Bacon Health Center, with various departments, under its sole jurisdiction.

The State Board of Trustees immediately assumed the responsibility in preparing plans, as prescribed by law, to remodel, repair, equip and maintain the buildings and grounds for the purpose of establishing the Governor Bacon Health Center.

The Center will be ready for dedication and for public inspection on September 27th, 1948. The Center will be opened for service on October 1st, 1948, at which time it will offer the following facilities: Seventeen buildings, well-equipped, to accommodate 282 children, who are either maladjusted, prepsychotic, or acutely psychotic, amenable to treatment; epilepties without psychosis, or crippled children or children awaiting for assignment to foster homes. Five buildings to accommodate 266 adults who are either epilepties without psychosis, alcoholics without psychosis or senile bed-ridden cases. In addition to the above, there will be five buildings to be used as dormitories for men and women employees; eight buildings to house doctors and their families; twelve buildings to accommodate the key personnel; nine buildings will serve as occupational, recreational, educational and physical training centers and patients' library.

There will be one large building designated as Medical Center with the following modern facilities: one major and one minor operating rooms, x-ray department, clinical laboratory, pharmacy, physio-therapy department, dental surgery, conference and library rooms, offices and autopsy room.

The Center will provide modern diagnostic

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and therapeutic facilities for the above described services.

There will also be two buildings for administration; one will be utilized as offices for the medical staff and business administration and the other for sub-administrative offices.

There will be a special laundry building and two buildings for housekeeping departments and various buildings for utility purposes.

The organization will be composed of: the superintendent; an assistant superintendent and medical director; six resident medical men, representing psychiatry, neurology, pediatrics, general medicine and orthopedic surgery; 10-15 part-time visiting physicians of various specialties, and a large staff of consultants; a director of nurses and her staff of graduate nurses and aides; a director of social service department and her assistants; a director of physio-hydro-therapy department and her assistants; a director of occupational, recreational and educational departments and her assistants; a director of dietetics and her assistants; a business manager and his assistants and helpers.

Eventually there will be a staff of a total of 250 employees to take care of 550 patients and out-patient clinics.

The primary purpose of the Governor Bacon Health Center will be to take care of acutely and sub-acutely maladjusted and ill children and adults, thus attempting to prevent our people from serious chronic disabilities and illnesses.

The objective of the Center will be complete or partial rehabilitation of children and adults of our community, who will be in need of such. The work will be performed on a state-wide basis. The Center will be the only institution of its kind. The Center will serve all classes of our people, who are in need of such care. It will be also an educational and training center. It will closely affiliate with the New York and Pennsylvania Universities as well as the Alfred I. duPont Institute, Delaware State Hospital and all the general hospitals, and the health and welfare agencies of the state.

PSYCHO-PHYSICAL UNITY

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The internist and surgeon must not permit themselves to think exclusively in terms of either structure or function. Always it should be an equal consideration of both at one and the same time. This has not been done previously. Structures have been emphasized and functions neglected. The school of pathology founded by Virchow has left such an impression upon medicine that the modern physician continues to be obsessed with the feeling that he must discover a defect in structure in order to account for disease in human beings. All of his efforts at treatment are dominated by this point of view, and he is often amazed to find that certain forms of therapy, which he regards as being unsound and as having no relation to the case whatsoever, frequently accomplish the desired result. Such an attitude needs to be corrected. The search for organic lesions is important, but it will never bring about a complete understanding of disease. A knowledge of the behavior activities and the reactions that follow an initial stimulus or fault is also necessary. This means that internal medicine must recognize frankly and completely the claims of function to a place of equal importance and reality with structure.

Functional disorders are spread thickly throughout each department of medicine and surgery. It has been conservatively estimated by numerous authorities that from 60 to 70 per cent of the patients seen in the dispensaries of our large hospitals, and in the consulting rooms of private practitioners, excluding the acute infections, present symptoms and complaints for which no adequate organic basis can be found. In spite of their frequency, however, these functional disturbances are commonly neglected, misunderstood, and improperly treated. They command interest only as long as they are considered to be diagnostic problems. As soon as it is discovered that the patient has nothing wrong with him, as we have often heard it expressed, he is passed over lightly, no further attention is paid to him, and he is referred to the psychia-

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trist. From a technical standpoint, most of these case do come under the broad heading of the psychoneuroses, but a great many of them do not. For practical purposes, as suggested by Peabody[1], the patient who has a functional disorder may merely be suffering from severe subjective sensations due to alterations in the physiological activities of one or more of the bodily organs. His symptoms may depend upon an increase or a decrease of a perfectly normal function, or simply upon his becoming conscious of a wholly normal function that is usually not noticed. Or as McDougall[2] would have it, functional disorders represent nothing but an ill-adjusted timing of the reactions of the various organs and an imbalance of their relations to one another. The ultimate causes of these disturbances of function are to be found, not in any gross structural changes in the organs involved, but rather in the influences emanating from the intellectual and emotional life of the patient, which may affect in one way or another any portion of the body. To say that an individual has a neurosis, therefore, because no demonstrable pathology can be pinned on him, so to speak, is wrong and not even logical.

It is extremely difficult at times to determine whether we are dealing with an organic disease or with a pure disturbance of function, and the differential diagnosis requires the broad training in the use of clinical and laboratory methods which forms the equipment of the internist. Then, too, the patients themselves very often fear the stigmata of any contact with the expert in nervous and mental diseases, and they prefer to go to their family physician. Certainly this reaction should not exist, but since it does, it is much better to recognize it and make the most of it than to completely ignore it to the disadvantage of the patient. Some of these cases, of course, are so refractory that they will have to be referred to the psychiatrist. The vast majority of them, however, can be helped by the general practitioner without the aid of highly specialized technique, if he will but appreciate the significance of functional disorders and interest himself in their treatment.

We are not justified in drawing a hard and fast line between organic or structural diseases, on the one hand, and functional disorders, on the other. The opposition between them does not rest upon a sound basis. Organic diseases are invariably accompanied by altered functions, while it is probable that an unlimited microscopist could always discover corresponding changes in structure in purely functional disturbances. Function is, in a large measure, dependent upon structure, and vice versa, and disease will continue to be an enigma until a definite correlation between them has been made. The internist will certainly expand his horizon and broaden his outlook, if he concerns himself with the vital capacities of organs instead of with mere changes in structure, and if he adopts a functional concept of disease. Such an approach will do away with therapeutic nihilism, because treatment will then be directed towards improving function rather than to eliminating the anatomical changes produced by disease, which may be, and usually are permanent. It is narrow-minded in the extreme for physicians to limit their interest to those disorders that are based solely on defects in the mechanical structure of the organism.

Every physical symptom, and every somatic reaction, whether physiologic or pathologic, must have reverberations in the mind of the patient. Conversely, each emotional or mental state has immediate repercussions in all the tissues and cells in the body. In other words, the mind cannot be kept out of any problem that affects the individual, especially disease. This is obviously fundamental in psychiatry, it is of equal importance in therapeutics, and it is of profound significance to the internist and surgeon. Every sick person, no matter what the nature of the malady may be, shows some variation from his normal mental state. Scarcely a single patient who is ill from an internal disease or after a surgical operation thinks and acts as he does in health. To put it differently, there is in every pathological condition, over and above the physical derangement present, a certain nervous and mental element, which varies in degree in different individuals, and which constitutes a more or less conspicuous part of the disease entity. In fact, there is a mental aspect to every illness, whether medical or surgical. In mild disorders, this amounts to little more than a group of disagreeable feelings, which call for no spe-

cial attention directed to their relief. In more serious situations, however, the nervous or mental element may, and often does, become a very important factor, in that it lowers the resistance of the patient, aggravates the organic pathology present, and hinders recovery. Every morbid process with which we deal is a psychophysical problem. This means that the practicing physician must always take into consideration the psychological, as well as the somatic symptomatology, in the study and treatment of disease, if the latter is to be fully encompassed, and if our methods of total diagnosis are to be improved.

We have no right to separate bodily and mental disorders, and to say either internist or psychiatrist, which is commonly done in medical practice today. Always it should be somatic and psychic treatment at the same time, and in the proper dosage and relationship. This is what psychiatry insists upon. Such an approach involves a complete study of every case, and requires, not only a detailed physical examination, including all the necessary laboratory tests and special procedures, but also an estimate of the personality make-up of the patient. If no organic basis can be found for his symptoms, inquiry should then be made into marital conflicts, financial failures, religious difficulties, sorrows, disappointments, anxieties, and thwarted ambitions. This can be diplomatically done without delving into the unconscious and without seeming to unearth buried sexual complexes. The physician will then be in a position to use drugs and diets at the same time with psychotherapy. It is necessary for all internists to possess a working knowledge of the mechanisms at the psychological level, and to recognize that they are just as definitely determined and as reasonable as the physical, chemical, and physiological reactions with which medicine has so long been familiar in its various departments.

The failure to recognize the concept of psycho-physical unity, together with the advances in scientific morphology, led rapidly to the partition of the body into various organs and systems. In relation to each of these anatomical sub-divisions, intensive research has opened up whole fields of professional endeavor, and specialization has developed. We have grown to look upon the diseases of the different organs as entities in themselves. Specialism in medical practice has been harmful in many respects, and it is essential to get away from too much of it. We need also to eliminate the gradually increasing tendency to consider diseased hearts, livers, and so forth, as organs for which the body provides a sort of test tube, and in the treatment of which the personality of the patient is irrelevant. A change in this attitude will eventually come about because of the newer emphasis in all phases of biological research on the importance of the unit or the whole to an understanding of its parts. The various medical and surgical specialists are certainly no longer justified in considering the organs and the diseases thereof in which they are primarily interested to the exclusion of the rest of the body. The organism is a unit and all of its parts are inter-dependent. Internal medicine, therefore, following the lead of psychiatry, must stress and emphasize the role which the anatomical and physiological units of structure whatever they may be, play in the whole economy, if it is to maintain its proper perspective, and not drift into too narrow a point of view concerning the human organism.

To know an organ and its diseases is the apparent aim of most medical specialists. The ultimate goal of the physician, however, should be deeper and more far-reaching than this. He should attempt to understand his patient as a total human being, with conflicts as well as a heart, with emotions as well as tonsils, and with thwarted purposes as well as a gastro-intestinal tract. In other words, instead of being interested in the pathological changes in some particular portion of the body, he should survey the whole individual. This will enable him to treat the patient from many angles and not merely from the standpoint of his chief or major disease. The real secret of the success of many practitioners of medicine is the thoroughness with which they grasp and apply the principle of psycho-physical unity to the baffling problems which they are called upon to solve. In order to fully comprehend and understand the nature of disease in our patients we must take cognizance of the situation within. It cannot be accomplished by an approach that lies wholly

from without, and that ignores the complex unit or whole which the interesting parts create.

From the standpoint of psycho-physical unity, the concept disease assumes a different and much broader meaning than is usually given to it. Disease arises from the interplay of dynamic forces, which are inherent in the individual, and which are present in the world about him. It is a subtly moving, changing set of reactions between man and his environment which cause him discomfort. To put it differently, disease is a physiological reaction of the organism under the influence of various noxious agents and emotional conflicts. As we have already pointed out, the organism responds as a unit or a whole to any problem confronting it. Disease represents, therefore, not the response of separate organs, or partial reactions, but total reactions to the causative factors whatever they might be. This means that there is really no such thing as a local disease, strictly speaking, and that all diseases are general in nature in that they affect the entire organism. The significance of these facts to internal medicine is that many chronic conditions whose etiology and pathogenesis are not known may possibly be explained as total reactions of the organism to long continued stresses, both from within and from without, the organic compensations and defenses of the tissues breaking down in certain directions, so that different organs become involved to a greater degree than others.

Because of the individual differences and peculiarities in all organisms, it follows that their reactions will be extremely variable, especially to disease, and that the symptoms of the same pathological condition will be different in each individual. This fact has long been recognized in psychiatry. In this branch of medical science, the psychiatrist seeks out the individual factors in disease, particularly as they express themselves at the psychological level, and by an understanding of them, he endeavors to work out something constructive in the life of the patient under his care. In other words, each patient who seeks help is individualized. This is the very essence of psychiatry, and may be termed its point of view, inasmuch as it is the only specialty in medicine that stresses this attitude. For a long time physicians have been studying and treating disease without a sufficient appreciation of just how the individual who had the disease was reacting to it. The general aphorism in psychiatry, treat the patient, not the disease, may be applied with equal advantage to all branches of medicine. A great deal can be accomplished by treating the individual factors in disease. Neglect of them may make all the difference in the world in the successful handling of the case.

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CROSS SECTION AND LONG SECTION IN PSYCHOSIS: SOME SPECIFIC IMPLICATIONS OF EACH

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A well-rounded psychiatric appraisal of any functional mental illness is derived from two main sources: (1) direct observation of the patient and (2) anamnestic data obtained from relatives, friends or the patient himself. Roughly, these two sources of information correspond respectively to (1) the cross section and (2) the long section of the patient's illness. Each is essential to an understanding of the case. The current trend in psychiatry is to emphasize the long sectional approach because this approach delimits the field of investigation by revealing specific mental constitution and sources of mental conflict. The development of the long sectional approach is one of the major advances of psychiatry. This factor alone serves to distinguish the modern era of psychiatry from its dark ages.

It is thus very understandable that psychiatry should be preoccupied with this most fruitful area of research. It does not follow, however, that an attack of mental illness is purely anticlimactic or that cross sectional evaluation need never be more than a perfunctory gesture. Psychiatry has no right to assume that because anamnestic data are clearly established ensuing illness is no more than an automatic resolution. Were such the case, prog-

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nosis would never be in doubt and psychotherapy would be obviated. Cross section must therefore be granted certain implications having no important root in the prepsychotic past, but containing intimations of the future, sometimes vague, sometimes clear-cut.

Most acute psychotic disorders must be conceived as representing a radical change in the patient's state or frame of mind. This basic change is a resolution of two vectors or elements, the first of which is static, the second dynamic. The static element has to do with the factor of alteration of consciousness in psychosis and must be regarded as a more or less latent function of the individual's mental constitution, becoming overt under the stress of overwhelming conflict. The alteration of consciousness may be severe or it may be insignificant or it may occupy any position between these two extremes. When the alteration is severe there is often to be noted a total amnesia for the psychotic attack after recovery. Alteration of consciousness may also be inferred from a profusion of hallucinations and delusions, symbolic and interpretable, and from a more general fragmentary oneiroid type of thinking seen in some psychoses. The important point to be noted is that dream like experiences do not follow the same economy as experiences in reality.

Delusions and hallucinations may disappear in the course of the illness, but even if they are clearly remembered as "imaginations" they can never be made to fit into the economy of full consciousness. They will remain something apart, strange and essentially unaccountable from the subjective standpoint. Insight into such experiences will always be more theoretical than actual. For the patient who remembers none of the psychotic experience there obviously can be no insight into the cross section of his disorder.

The second element of the basic change, the dynamic element, and that which constitutes the body or substance of the psychosis is affective in nature. When consciousness is greatly altered this second element may only be inferred through interpretation of hallucinations and delusions or through observations of general behaviour. When consciousness is only slightly altered or not altered at all, the naked, unmodified affective change becomes apparent.

From intelligent patients who possess good introspective capacities we will often obtain striking descriptions of the basic change. There is surprisingly small variability among these expressions which record sentiments variously designated as incompleteness, depersonalization, anhedonia, void and unreality. Perhaps the concept of anhedonia is basic while the others are more or less derivative, but the actual differences among these modalities are slight and there can be but little doubt that the matrix for all of them is affective.

Let us consider, for example, the case of a young man, aged 26, who underwent a sudden psycholeptic attack while hiking in the country one day. Subjectively it appeared to him that a sort of vaporous curtain descended before his eyes giving a harsh metallic appearance to the natural objects in the environment. The tree trunks looked as though they were made of papier mache; the grass of green tinsel. He did not grasp the meaning of this phenomenon spontaneously. While beating his retreat home he passed a very attractive girl and suddenly knew that he had utterly no emotional response to her. This realization seemed to dispel immediately the hallucinatory cast of natural objects. Here the interpretation seems clear-cut. Tree trunks of papier mache, grass of green tinsel are harsh artificial objects devoid of any natural appeal. The hallucination is a symbolic expression of failure of emotional response to these natural objects.

Somewhat similar was the experience of a young woman who looked at the sun one day and found that it looked "just like the moon." Obviously, a sun which "looks like the moon" is a sun devoid of all of its warmth and life-giving quality, appearing as a dead planet. This is equal to the statement, "for me the sun has lost its emotional appeal." In both of these cases there can be no doubt that the semi-hallucinatory experiences were expressive of subjective actuality and did not represent mere poetic modes of expression.

The hallucinatory experiences in the two foregoing cases are strictly non-specific in a long-sectional sense, but they are highly specific from the cross-sectional standpoint. They

reveal nothing of the prepsychotic individual, his conflicts or his personality. They are expressive only of the essenec of the affective change which has taken place within him. Nevertheless the major portion of his thinking for many months to come will be predicated upon this affective change. His gradual improvement and perhaps even his recovery will depend upon his capacity to accept, adjust himself to and ultimately modify this change. No probing of prepsychotic conflicts or personality defects will shed any light upon the intrinsic mechanics of this condition, once it is established, or in any way enable the patient to deal with it. It is a new order of things following a new economy. The insistent demands of this new economy must be learned and served by the patient before he can profitably turn his attention to antecedent conflicts.

To illustrate this point let us consider the case of a young man of twenty who rather belatedly had completed a high school education and was looking forward to college. Although he had been obliged to divide his time between farm work and his studies, he had achieved excellent grades in high school and was elected president of the senior class. He was furthermore an outstanding athlete. In the summer following his graduation it became apparent that the family finances would not support him in a college career and that he would be obliged to continue his chores on the farm. He accepted this turn of fortune without comment. But after an interval of about two weeks he suddenly went into a state of uncomplicated anhedonia necessitating hospitalization. In the hospital he was quite unable to perceive the connection between his disappointment and the anhedonic reaction. Subjectively the anhedonia seemed entirely too strange, unidentifiable, and all-pervasive to be a reaction to anything. Over a course of six months in the hospital he gradually worked his way out of the anhedonia and it was not until he was about to leave the hospital as recovered that he could begin to appreciate the relationship between the disappointment and his mental reaction.

Uncomplicated, unelaborated anhedonia is not so frequently encountered, but the element of anhedonia is to be found in a considerable number of functional mental disorders. When it is present it dominates the picture as in the following.

A Jewish woman, 55 years old, the mother of four children, developed a severe state of melancholia following her husband's financial reverses during the economic depression. Hospitalization was necessary. She wailed tearlessly day and night muttering stereotypically that her children had been tortured to death. When her children came to visit her she would stare at them stupidly, later stating that the people who came to see her were imposters sent to mock her. Her delusions that the children were dead is tantamount to, "for me they are dead in an emotional sense; I have lost all maternal feeling." From her general behaviour one would have judged that she had lost all other feeling in addition. It is quite possible that her failure to shed any tears (a common finding in severe states of melancholia) was a physiological expression of loss of emotional substance. This factor and her delusion indicated a basic anhedonia, but the delusion, in addition, pointed to the fact that her primary emotional investment was in her children, as is often the case with Jewish mothers. In this instance the delusion revealed certain reflections of the prepsychotic life although these reflections were of no etiological significance.

In the cases cited thus far anhedonia has been a prominent if not an exclusive feature. Let us next turn our attention to some psychotic phenomena which are not an outgrowth of anhedonia.

Following is an example: A 40-year-old male was admitted to the hospital because of physical violence against his wife based upon delusions of infidelity. He was tall and heavy set, a plain clothes man on a large city police force. For several months prior to hospitalization he had been neglecting his usual beat in order to spy upon his wife's activities. The wife gave a convincing account of her own innocence but stated that she was afraid to go to any mixed social function with her husband because of his tendency to create scenes by his accusations. The patient revealed a normal affective tone and could talk quite logically about matters which did not concern his wife. Nevertheless, he was pressed for details of his own comings and goings and he finally admit-

ted that over a period of years he had been indulging in illicit sexual relationships with five or six women on his beat. He was desperately afraid that his wife would discover this fact, would reveal it to his superiors and cause him to lose his job. Upon making this revelation his paranoid thinking relative to his wife disappeared.

In this case the delusion is directly and specifically related to the etiological situation. There was no intervening anhedonia and the long-sectional aspects are all that need be considered. The implications of the delusion of infidelity are purely local and the case as a whole shapes up more as an acute neurosis than as a psychosis involving a totally altered consciousness or affectivity. Recovery therefore required no major effort of adaptation but took place automatically after psychocatharsis, thus differing radically from the more gradual recovery in anhedonic states. It seems probable that a single dominant emotion such as fear, guilt, shame or something allied may directly usher in morbid symptoms without interposition of a totally altered mental state in certain individuals.

Following is a more serious disorder illustrating the same point. A 55-year-old female mulatto has been in the hospital since 1934. At times she is grossly delusional but her personality is well-preserved and she reveals no evidence of anhedonia or elation. She professes a deep interest in the problems of the colored race and has been of considerable help in the management of certain colored patients on her Ward. Nevertheless, she seeks privacy and because of her trustworthiness has been accorded the privilege of having a double lock on her door. Other colored patients do not seek to enter her room but after she has left the room for a short while she inevitably believes that she finds evidence of their presence. Her most persistent complaint is that they spray mucus on her bed. Her early history is revelatory and quite unusual. She is the daughter of a white woman and a father of mixed colored and American Indian blood. The father and mother separated shortly after her birth and she was reared by her mother. All of her friends and associates were white people and there was never any question of her acceptance in the social group. At age 17 she overheard gossip relative to her paternal blood and at this time her mother admitted to her that the father was a colored man. The patient immediately renounced her social situation and devoted all her efforts to acquiring an education as a public health nurse. Due to an excellent native intelligence she was quite successful in this work over a period of years but at age 42 her hospitalization became necessary.

In this case the delusion that mucus was being sprayed about her room by other colored patients seems to represent the quintessence of her conflict which had its origin almost 40 years previously. After all, what is more intimate than mucus? In a welter of intercurrent delusions this basic conflict from her far past seems well-preserved. The delusion is completely specific to the etiological situation.

Consider now some delusions of lesser etiological specificity but none the less revelatory of long standing conflict. A catatonic girl in her early twenties had lain almost immobile in a hospital bed for several months. She entertained the fixed delusion that the Lord Jesus had taken up abode under her bed. One morning she related that on the previous evening the Lord Jesus had reached up and pinched her on the thigh. This revelation is a commentary upon the drab, timid existence which had been her prepsychotic lot and one can deduce the essentials of her entire stream of conflicts from this single delusion, which represented her method of compensating for the emptiness of her existence.

Somewhat similar is the case of a celibate and recluse, aged 50, sent to the hospital because neighbors had complained that he was peeping in their windows. He was an intelligent man and had read omnivorously. Among his delusions was the belief that on certain evenings he could have sexual intercourse with angels. This again is compensatory for psychosexual denial. His delusions were at all times fantastic but the following seemed to represent his best achievement. He liked to chew tobacco, which practice was forbidden in the hospital. On walking parties he would sometimes lag back in order to pick up and secrete on his person any old cigar snipes he could find. When the attendant was not looking he would stuff these cigar snipes in his mouth. When attendants seemed in a way to

detect his violation of the rules he would swallow the cud, and it was after he had initiated this practice that he began to complain of gastric pains. He was quite unable to accept the simple and obvious explanation of his pain, however. His own explanation was as follows: There was a series of wicked kings on the planets Arcturus and Pleiades who had oppressed their subjects and who, when they died, were confined to his head as a sort of purgatory. In his head was a number of revolving steel drums, each containing a wicked king. Underneath the drums were hell fires and within the drums were whirling knives. He designated these drums as "skittering machines." When each king had been sufficiently skittered the net effect was to render the king nauseated, causing him to vomit. Vomitus descended from the patient's head to his stomach thereby rendering him nauseated.

This trend all followed the ingestion of cigar butts and it bore no specific relation to basic confliet, but at the same time it was highly revelatory of and compensatory to the drab and constricted life this patient had led. The dereistic type of thinking which characterized this trend as well as practically all of this patient's other productions was a conscious intellectual elaboration beyond any shadow of doubt. It is completely lacking in the spontaneity, neatness and trenchant symbolism which characterize those delusions and hallucinations based on immediate unconscious needs.

CONCLUSIONS

1. Many acute psychoses in cross section present a radical change in the patient's state or frame of mind.
2. This change has two main components (a) An alteration of consciousness of varying degrees and (b) the affective or anhedonic element, almost invariably present.
3. Alteration of consciousness with its attendant phenomena of amnesia, oneiroid thinking, delusions and hallucinations prevents the process of adaptation to the psychotic defect and materially alters insight and prognosis.
4. In certain cases specific conflicts may lead directly to specific morbid symptoms without interposition of a totally altered mental state.
5. In chronic cases there are sometimes encountered delusions and hallucinations of general rather than specific meaning. Such findings have more remote implications, and tend to throw into relief the general outline of prepsychotic personality rather than acute conflicts. In these cases the thinking is characteristically dereistic and is consciously elaborated.

THE PROBLEM OF PSYCHIATRIC ETIOLOGY

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In a recent paper this writer gave expression to his views on what he regarded as standbys and pitfalls in the field of psychiatric diagnosis. The problems of psychiatric diagnosis have become more acute again as various ways of simplifying the present standard nomenclature of psychiatric conditions have been proposed. A general criticism of such attempts appears timely. Some authors take a delight in giving a new name to an old thing without changing it a particle. While these proposals no doubt reflect the earnest desire of qualified investigators to come to grips with the presently existing terminological inadequacies of the roster of mental disease, they have largely remained theoretical and strictly semantic efforts in condensing the unclear interrelation of those affections of the mind that are still in many quarters described as functional, however strong the inroads made by the vast organic area. This is readily exemplified by the great majority of the organic deficiency states. The idiot and imbecile levels of mental deficiency are the preponderant domain of organic reactions. So are all so-called secondary or acquired states of psychopathic behavior, be it traumatic, infectious, epileptic, or other. But primary deficiencies and psychopathies are said to be linked to hereditary or constitutional factors, obviously factors of a strong somatic determinant. It is not necessary to repeat the basic tenet of the unitarian formula in regard to

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body and mind. What is so much more urgent is the soundness of our etiological quests.

The investigation of the psychological mechanisms underlying abnormal behavior will, at best, offer the most plausible explanation of its appearance. Any such attempt at interpretation will be colored by the psychological insight of the investigator and by his mode of thinking in terms of his pet theories or, if he is objective enough, in terms of the experience of the individual patient under observation. To make psychological factors etiologically meaningful the investigator has to reduce them to the scale of etiological thinking that admits them as part of a greater whole in the study of the etiological field. Psychological factors may elucidate the origin of some mental reaction, and yet reveal only a single etiological aspect. To be more specific, the law of causality may be psychologically fulfilled by analytic candor, but certainly not always biologically. While neurotic conflicts are subject to resolution, the inherent personality disposition and its constitutional foundation are unaffected by therapy. It is evident that any other etiological factor is just as important as the psychological factor, and it is just as evident that the psychological factor often is not the only one of etiological importance.

It should be a routine procedure to investigate all etiological factors with complete disregard of their personal preference value. Psychiatry is first of all a discipline of medicine and thus follows and adopts anything and everything that is compatible with the highest medical standards. Or should the psychiatrist leave the study of heredity to the geneticist, the study of constitution to the anthropologist, the study of the body function to the internist, the study of social aspects to the sociologist, the study of the nervous system to the neurologist and the interpretation of the psychometric test results to the psychologist? This would seem almost inevitable if one followed the views expressed by Ben Karpman who seems to believe that institutional psychiatry has reached a dead end.

It is necessary to emphasize the multiplicity of etiological factors in the understanding of mental disturbances. There are at least four major etiological factors to consider in each case: the genic-constitutional, the somatic, the psychological and sociological. But all these factors require individual consideration and objective re-integration. It is common experience to observe that the etiological inquiry, the interpretation of the symptom development, the understanding of the role of certain symptoms within the frame work of a definite mental disorder, and of the interrelation between different symptoms within the individual reaction set do not always meet with the desirable sense of objectivity, proportion and balance that the biological study of mental disease demands.

Personal ideologies of the observers are often introjected which tend to distort and to falsify even trivial facts, and may lead to thorough misconception of problems of etiological or diagnostic significance. Thus, it is not surprising that constitutionally or environmentally or analytically directed orientations appear to be used as keys to the assessment of very intricate and complex situations not easily reduced to simple components or simple relations of a one-sided order. It actually means that the true dimensions of most of our classical entities are subject to the most arbitrary and inconsistent calculations. Moreover, it seems impossible to state where one syndrome ends and another one begins, unless we disregard the existence of important intermediate or mixed conditions, and the views of experts are still at variance where unanimity would be of real advantage.

It certainly is not enough to pigeon-hole a case of schizophrenia as some pattern of mental dissociation. It is logical to ask about incidents of mental illness in the family, to take anthropometric measures, to investigate the glandular balance, to inquire into the past and present physical, mental, and social development, into the physiological and psychological functions of the organism. Is protein deficiency a factor? Or an obscure toxic or infectious element at work? How did the abnormal symptoms develop? What do they mean to the patient? Is there an inherent developmental deficiency? What, I would like to ask, constitutes a *complete* study of a case of psychosis, and what of neurosis, or psychopathy or mental deficiency? Once a general agreement is reached on the basic requirements, the different etiological levels will find their proper

answer. Moreover, let us not forget that there is still the great unknown, that most of our present theories are too speculative, and that clarity in etiological thinking is the prime requisite for therapeutic success. Psychiatric diagnosis infers proper knowledge of psychiatric etiology. Adequate psychiatric classification has to consider the multiplicity of the etiologies no less than the array of surface phenomena now used as criteria for differentiation. Psychiatry has to go beyond the limitations now erroneously imposed by blind followers of the orthodox or analytic schools.

No revision of nosology will meet the demands of the psychiatrist unless it provides for a multiple etiological system. Present theories are exclusive and unitary. They are incapable of illuminating the multiple psychobiological factors involved. One factor should never be given one-sided preference over another in a multiple factor constellation.

It is possible to give three different diagnoses for the same condition, and each diagnostician may be partially correct for the simple reason that the patient may present a set of three etiologically independent reaction patterns. If only one diagnosis is made, it is likely to be less correct than three different diagnoses. Furthermore, each diagnosis should be evaluated according to the degree of each reaction so as to account fully for the total variance of the patient's problems.

Most abnormal symptoms seem to pervade many and varied categories of psychiatric nosology. They appear as variable aggregates of a limited number of basic components. The experimental study of these primary determinants is still inadequate.

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THE PSYCHOSOMATIC DILEMMA

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All is not well in psychosomatic medicine. Eager psychiatrists who offer their interpretative services to colleagues in various medical fields encounter criticism which can be summed up with the recent statement of a noted internist: "it used to be matter over mind, now it has become mind over matter." The psychosomatic idea is based on the recognition of the indivisible totality of the living persona. This concept gained forceful momentum in reaction to an era of cellular, bacteriologic and laboratory-minded medicine. Modern psychiatry offered a wealth of new information on the subject of personality function. Tired of rigid text-book classifications, the physician of today aims to see the patient in connection with his life situation, cognizant of the complexity factors which contribute to many states of illness. There is today no principal disagreement on the necessity of a psychosomatic orientation in medicine.

The question at this point seems to be whether certain methods of psychosomatic interpretation are valid, factual and products of the same scientific discipline of thinking to which modern medicine owes its epochal progress. This is precisely the issue on which opinions are divided. Criticism concerns the apparent tendency to solve complex etiologic problems on the basis of psychologic assumptions and to substitute new artificial categories for old ones, condemned as "descriptive." Indeed, studying the current literature we find such monstra as "upper gastro-intestinal disturbance personality" (peptic ulcer) and "lower gastro-intestinal disturbance personality" (colitis). The patient unfortunate enough to develop high blood pressure has been assigned to the department for "repressed hostility" and those with coronary diseases are said to be compulsive personalities. The obesity problem has been solved at last in favor of psychogenecity and the dermatologist who still prescribes lotions wastes time treating tissue instead of exploring the unconscious. Surgery emerges from the ideas of the pan-psychologic school as an outlet for aggressive sadists. Surely radical trends can be found in any orientational evolution but the fact appears to be established that even among more moderate "psychosomaticists" a tendency toward fanciful generalizations has become noticeable.

Conceptional Confusion

Distorted psychosomatic ideas are the outgrowth of confusion on principles of etiology. In theory there is complete agreement on the complexity of causative factors, in actuality

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ideas are either physiogenic or—the new danger—psychogenic. A peptic ulcer is still attributed to hyperacidity by some or now to an ambivalent, affection-hungry personality by others. We are concerned with the questionable psychologic formulation which is so dangerously popular in current psychosomatic presentations. If the pneumococcus does not constitute the final answer to the pneumonia problem, a certain personality-profile cannot be the last word on the etiology of functional disorders. Cooperative personality factors have been generally accepted, however, the nature of these factors cannot be reduced to unconscious-slogans. Neurovegetative instability causing overactivity of secretory and motor fibres of the vagal nerves represents the functional element in the pathophysiology. Nobody, not even the most exact psychoanalyst, can decide whether emotional factors "cause" the neurovegetative instability or are to be considered another aspect of an intrinsic disposition manifesting itself in functional and emotional liabilities. Henriette Klein (The American Journal of Psychiatry, January, 1948) studied 100 unselected patients attending a G. I. Clinic and brought out some sobering facts: "Some of the formulations of previous observers have been exaggerated by avid followers out of proportion to the original facts. The material in our series would indicate that specific gastro-intestinal illness cannot be correlated with any one personality type marked by a prepotent need. On the contrary, from our data it is apparent that specific or intrinsic illness occurs in a variety of personality types, marked by different psychological constellations. Details of these personality types and the mode of correlation must be established in each case." This objective evaluation of psychosomatic correlations is an exception rather than a rule as can be seen from comparison with other presentations. We are told again and again that it is the conflict between powerful dependent needs and the aggressive solution of this conflict in the face of frustration of the receiving tendencies which is of crucial importance for the development of peptic ulcers. No wonder that analytical psychotherapy is already proclaimed to be the only "etiologic" kind of therapy. Such dogmatic standardizations of personality factors, perhaps present in some selected cases but totally absent in the majority of patients, interfere with the individualization of case concepts, which is supposed to be the basic principle of psychosomatic orientation.

The same holds true for certain sociologic factors which are now in danger of being overevaluated and stigmatized. Our social and cultural structure demands flexibility of the personality and imposes a strain on individuals lacking in inner security. We have significant evidence of interrelations between sociologic and medical aspects of groups and types of society. However, to exclusively attribute disorders to specific influences of our kind of society means to oversimplify etiologic relations. Certainly other cultures with a slower tempo of living and static socio-economic class structures have their share of the same disorders. Only comparative investigations based on equalized diagnostic criteria and covering an extensive variety of cultural, racial and political entities on a world-wide basis could provide deeper insight into the relations of disease and society. A visiting physician from a South American country who attended a recent meeting on psychosomatic medicine seemed perplexed about our emphasis on cultural factors and inquired how we would evaluate the very same disorders in the situations of his own patients whose living-habits differ tremendously from that of our population. Psychosomatic thinking can neither be based on well meant sociologic platitudes nor on outdated analytical concepts.

The Inevitability of Constitutional Thinking

Fifty years ago constitutional theories were static and based on misunderstanding of genetic laws. Today constitutional thinking means recognition of individual differences, appraisal of capacities and potentialities. The biological basis for individuality becomes more apparent and tangible with the progress of our sciences. No longer can constitutional thinking be identified with typological schemes, on the contrary it aims to comprehend the uniqueness of the individual. No ready made formula can explain why one patient under certain circumstances develops a disease whereas others exposed to the same influences do not or become afflicted in a different manner. Unfortunately most psychia-

trists pay little attention to modern genetic and constitutional researches, in fact the term "constitution" is practically taboo and still associated with therapeutic nihilism and reactionary organic-mindedness. Internists have no difficulties in acknowledging the constitutional nature of diabetes mellitus. It did not stop them from discovering insulin-therapy, now one of the greatest therapeutic achievements of modern medicine. To the intellectualistic mind on the other hand it appears more stimulating to define unconscious conflicts as "the causes" of disorders than to investigate to what extent the patient's constellation of emotional characteristics represents his biologically determined temperamental disposition. An example will demonstrate this non-objective attitude of certain psychiatrists. Alvarez, the distinguished advocate of psychosomatic awareness in the clinical practice of medicine, described a type of patient, often morphologically poorly developed, of low resistance to infection, low threshold for pain and of weak energy-potential. Such patients are, as is well known, too often treated on the basis of local symptoms and become easily multi-operated victims of medical incompetence. To stress the impossibility of a truly causal therapeutic management Alvarez named these patients "constitutionally inadequate" and advised psychotherapy based on recognition of the inner difficulties associated with the physical deficiencies. One would expect a sympathetic psychiatric echo.

On the contrary, however, from the dynamists came severe criticism and rejection of the formulation which was called "condemnatory." As a practical result, some of these patients who were formerly mutilated by surgical pragmatism now suffer new undeserved agonies during psychotherapeutic procedures devised by compulsive analysts bound to get "at the bottom" of the trouble in order to find "the cause." We are now in danger to diagnose "rejection" (by parents, husbands or wives) as easily as ptosis of the stomach, floating kidney or focal infection in days gone by; to blame "sibling-rivalry" or "repressed hostility" for disorders formerly attributed to vitamin-deficiency or malposition of the uterus. In other words we now replace the idea of exclusively physical etiology with one of strictly psychologic quality. The situation can be reduced to an either-or-philosophy, one mechanistic the other intellectualistic, but both unbiological in conception. Freud once complained of "the constitutional incapacity of men for scientific research" and thus diagnosed the emotional element which interferes with objectivity. We are now always told that constitutional data are incomplete. But no effort is made to stimulate or support constitutional investigations and it is conveniently overlooked that this science is still young. What Freud wrote in defense of psychoanalysis describes equally well the situation of constitutional psychiatry: "in no other field of scientific work would it be necessary to insist upon the modesty of one's claims. In every other subject this is taken for granted; the public expects nothing else. No reader of a work on astronomy would feel disappointed and contemptuous of that science, if he were shown the point at which our knowledge of the universe melts into obscurity."

Research in Constitutional Clinics in many countries, in our own universities investigations by Draper, Sheldon, Kallmann and Bauer (and many others) have produced a wealth of decisive data on the subject of constitution and disease. The boring old controversy on the priority of inner disposition or situational influences has long been settled in favor of the formulation; heredity determines what one *can* do, environment what one *does* do (Bauer). It would be foolish to say that Caruso became one of the greatest singers because he had excellent vocal lessons or that Rubinstein became the famous pianist because his parents sent him to the conservatory when he was still a child. It is equally insufficient to reason that a patient develops a disorder "because" of a situational factor since in his case as well as in that of the virtuoso we need to know the intrinsic capacities without which the environmental setting could not have exercised a specific effect. *Any* disorder concerns the individual in totality. Constitutional thinking facilitates the most individualized methodologic type of investigation. The examiner does not proceed through channels

preconceived and pre-fabricated, but is guided solely by the individual aspects of the patient be they morphologic, biochemical, immunologic, characterologic or *experimental.* Experience is an existential process as the individual becomes aware of his existence in situations. The psychiatrist must develop insight into the individual's manner of experiencing. There can be no equation type of psychology according to which a certain situation or sequence of events produces a certain personality profile. The study of life histories informs us about *occurrences,* but not about *experiences.* Mass production of sociologic or psychologic formulas does not help us to understand an individual's capacity for experience and without comprehension of this capacity which is constitutional, depending on the intellectual and temperamental endowment, we cannot be aware of the patient as an individual.

A profound truth on the subject of constitutional capacities can be learned from Kinsey: "There is an inclination among psychiatrists to consider all unresponding individuals as inhibited, and there is a certain skepticism in the profession of the existence of people who are basically low in capacity to respond. This amounts to asserting that all people are more or less equal in their sexual endowments, and ignores the existence of individual variation. No one who knows how remarkably different individuals may be in morphology, in physoilogic reactions, and in other psychologic capacities could conceive of erotic capacities (of all things) that were basically uniform throughout a population. Considerable psychiatric therapy can be wasted on persons (especially females) who are misjudged to be cases of repression when, in actuality, at least some of them never were equipped to respond erotically." (Alfred Kinsey: Sexual Behavior in the Human Male). This is the perfect demonstration of the deficiency of intellectualistic libido-concepts and the inevitable necessity for constitutional thinking. No better example can be found for the characterization of the psychosomatic dilemma and its cure through a more realistic orientation.

A CASE OF INVOLUTIONAL PSYCHOSIS, PARANOID TYPE

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The present official classification of mental disorders include the involutional psychoses among those due to disturbances of metabolism, growth, nutrition, or endocrine disfunctioning. While changes at the somatic level of integration undoubtedly contribute directly or indirectly to the disorders of personality included among the involutional psychoses, yet the author considers that factors other than disturbances in these functions are more important in their production. Whereas formerly only one type, melancholia, was included among the involutional psychoses, the present classification recognizes as a separate type those cases in which paranoid features constitute the presenting symptoms.

A certain number of persons develop a paranoid psychosis during the involutional period. Although never previously psychotic, nearly all such persons will be found to have been ones whose pre-psychotic personalities were characterized by defensive patterns. Like those persons who develop melancholia at the involutional period, the life patterns of the ones who develop an involutional paranoid psychosis have long betrayed an underlying sense of insecurity which he has striven to meet through certain character traits. Usually it will be found that he has been critical of others, inclined to blame other persons for his failures, has seen slights where none were intended. By his associates he was probably regarded as obstinate in opinion, jealous, unforgiving, secretive, decided, and perhaps suspicious. These characteristics or reaction formations proved sufficient support for the personality until the involutional period, when, with the added physiological and psychological burdens which may have attended the climacterium, they were no longer adequate, and resort was had to the more extreme defensive and compensatory measures provided by the paranoid psychosis with its delusions, misinterpretations, and distortions of reality.

CASE REPORT

L. B., a 53-year-old colored female, was admitted to the Delaware State Hospital on

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January 8, 1948, from her home in southern Delaware. Family history was fragmentary and did not appear to be contributory to the patient's present condition. Personal history revealed that the patient was born in Maryland 54 years previously. No history was obtained concerning her early development. She went as far as the 8th grade in school and was always considered of normal mental status. She has been said to be friendly and sociable toward all the people she met but was not one to meet strangers easily nor to inject herself into other people's business. She was of a quiet disposition and spent most of her time at home. She was considered happy, cheerful, truthful, kind and generous. She has always been a serious person and never one to go in for any foolishness; she always minded her own business and never gossiped about others. She has been extremely clean in her person and in her own home. Has always been very religious and has devoted much of her time to church work. She married at the age of 18 and her first marriage lasted 7 years. Her husband died 26 years ago. There were two children of this union. Eleven years ago she remarried again and lived with her husband for four or five years. She left him in North Carolina because she did not like the state and came to Delaware where she has lived alone ever since. She has always been perfectly healthy until about five years ago when she started to suffer from dizziness and hot flashes. She has been under the doctor's care off and on since then and has had injections for this trouble since. She apparently has had no menstrual periods for the last six or seven years. She has worked hard all her life. For the past number of years she has worked as a domestic and has worked regularly and faithfully, even up to the day before she came to this hospital. She has been very well thought of by both white and colored. She is proud of the position of respectability that she has acquired in her home town. She is proud of her reputation for industry and honesty. She is solicitous for the good opinion of all and guards her impeccability solicitously.

As to the onset of present condition, patient's true mental condition has apparently not been known to her daughter, with whom she has been living. The family knew that she has been extremely nervous for the past two years; that she would be depressed and have crying spells. They declare that she has always talked coherently and relevantly and that her conduct was never bizarre. She did tell them that she heard voices but would never tell what the voices said. Her gait and speech have been normal. The family denies that she has had delusions or grandiose ideas. They did not know that she was coming to this hospital until the officers came for her. One of the officers did remark that the patient had been in almost daily communication with him concerning her troubles.

Physical examination reveals an obese colored female about 54 years old, clumsy and incoordinate because of her extreme weight. No other obvious difficulty is noticeable. The laboratory tests, including blood Wasserman and spinal fluid examinations, are all negative.

As to the course in hospital: Patient was eager to come to the hospital and says she wrote in asking if she could be admitted. She thought that here she could be given relief from the paresthesias that plagued her. Her stream of mental activity was easily set in motion. In fact, she starts spontaneously to enlarge upon her troubles. She is firmly convinced of the reality of her complaints and gets excited describing her wrongs. She is somewhat repetitious but her memory seems perfectly clear, and gives chronologically correct accounts of her affairs. She is overwhelmed by the indignities and persecutions that have befallen her. Her content of thought concerns itself entirely with a systematized delusional system concerning the indignities at the hands of her doctor at home. He took some blood and diagnosed syphilis and insisted that she take some treatments for this but she is convinced that this was a blind to cover up his nefarious design to keep her coming to his office where he allegedly made sexual advances to her. She submitted to this for some months before she got on to what was going on. She then refused to return. Since the doctor has persecuted her by means of his voice. This voice has hounded her for several months past and is still right there. It has interfered with her work in the past and threat-

ens vile things even now. She answers the voice, she says, but some influence from the voice keeps it from being heard by others around her. It has threatened to kill her; to burn her up. The violent burning that she feels over almost her entire body is the work of this evil influence. While she was at home she says she did her work in her bare feet because the burning made it impossible for her to keep her shoes on. Since she has refused to submit, the voice threatens and curses her and still makes the same lewd suggestions and proposals as before her admission. Sometimes she talks back to the voice. At other times she defies it and refuses to talk. This alone is the burden of her troubles. She is clear in all spheres and knows about this hospital, why she is here, and what she expects of it. She is in good contact with reality except for her circumscribed delusions concerning her home town doctor. She came here because she thinks we have the means of relieving the burning in her feet. Her memory seems clear; her mental capacity is decidedly limited. Her school and general knowledge are fragmentary. Attention is intact. She seems alert to her surroundings. Her definitions of contrasts and similarities are primitive.

About eleven weeks after her admission patient's delusional system seemed to fall away from her suddenly and miraculously. She heard a voice telling her that if she kept her lips tightly pressed together the voice that speaks to her would be silenced, and also if she pressed on the top of her head where her family doctor had put some influence on her, the burning of her body would stop. She tried these things and was delighted to find that the prediction was true. She was, of course, very much relieved; she had her first good night's sleep and she was satisfied that she was cured of her trouble forever. This entire freedom from delusions and all other psychotic symptoms has held up to the present time and she is being considered for parole, five months after admission.

Formulation: This is a circumscribed delusional structure concerning the alleged evil designs of her home town doctor, a white man about 60 years old and with a grown family, whom she has known and patronized as the family doctor for many years past. All went well until some several years after the menopause became established, at which time she went to him for treatment to relieve her hot flashes and nervousness. The doctor evidently performed a pelvic and other physical examinations in the course of his obligation to her and proceeded to give her regular injections, probably hormones, thereafter. Patient then developed the delusion that she had syphilis and that the doctor says that he was treating her for that. She also developed the thought that the regular calls to the doctor's office were really a blind erected by him to fool the public and to keep her coming to him so that he could possess her sexually. He has never acknowledged this in his person to her, but by means of his voice, which enters into her mind at all hours of the day and night, and he gives her directions for meeting him and submitting to him. The voice becomes especially lascivious at night. It threatens that he will burn her; that he will kill her, if she does not submit; in fact, if she ever informs anybody about him.

Patient is now 54 years old; has been living as a widow for a number of years past. Apparently at this time she has had a recrudescence of a dormant sexual impulse—possibly produced by the prolonged administration of estrogenic hormones. The forthright satisfaction of such an impulse under her circumstances is impossible: She is a respectable, hard-working widow, highly thought of by her white and colored colleagues; a pillar of her church, devout, superstitious, soul-searching; solicitous for the good opinion of all; proud of her reputation for sobriety and decency; guarding her coveted respectability at any cost to her mind and body.

A diabetic patient beginning to show unusual features, and particularly to our experience recurrent colds, or persistent head colds, should be submitted to x-ray examination of the chest; a search for tubercle bacillus in sputum and fasting-stomach contents should be made, and the blood sedimentation rate ascertained. W. R. Gauld, M. D., and A. Lyall, M. D., Brit. M. J., May 17, 1947.

+ Editorial +

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DELAWARE GOING FORWARD

About 20 years ago, the little state of Delaware assumed the responsibility of preventive mental health on a state-wide basis. This unique project offered adequate services to the people of the state by establishing the Observation Psychiatric Clinic and traveling mental hygiene clinics under the direction of the Superintendent of the Delaware State Hospital. Many thousands of people have been helped and serious psychiatric problems have been solved. Because of these two well-organized units of mental health, the increase of the population of the Delaware State Hospital has not been as high as might have been expected.

Delaware again is assuming its leading place in preventive medical work. On September 27th, 1948, the State Board of Trustees of the Delaware State Hospital will open at Delaware City the Governor Bacon Health Center, which will offer state-wide preventive and curative services. This Center will be a unique hospital affording service to about 300 children, and more than 250 adults.

In the past only a few parents could afford to send their mildly or severely maladjusted children to private schools or institutions. For the first time in the history of our country, the state will assume the responsibility for the care and treatment of such children. Crippled children, particularly the cerebral palsy cases, who are not receiving any hospital care for their rehabilitation, will have an opportunity for treatment. Children suffering from epilepsy or from epileptiform convulsive seizures will also have opportunity for hospitalization. Adults suffering from epilepsy without psychosis will have a chance for adequate study and treatment. Above all, alcoholics without psychosis, who in the past have been treated as step-children of society, will for the first time be considered as sick persons who are in need of professional help. Some of the bedridden terminal cases requiring constant bedside care, will also be accepted.

The medical profession at its annual meeting in Dover two years ago, unanimously approved this project. We are happy to learn from Dr. Tarumianz that he will have adequate resident, visiting and consulting physicians—specialists in various fields of medicine.

We wish to congratulate Governor Walter W. Bacon, the members of the General Assembly of 1947, the State Board of Trustees of the Delaware State Hospital, many friends of the people of the state, who have taken an active part in promoting this project and above all our colleague, Dr. M. A. Tarumianz, who through his untiring efforts has obtained free of charge the Fort Du Pont Reservations and transformed a war plant into a unique and worthwhile health project. It gives us great satisfaction that the Health Center will be affiliated and closely coordinated with the work of our renowned Alfred I. du Pont Institute for crippled children. It will also be a great honor to have affiliation with the medical schools of the Universities of New York and Pennsylvania.

THE JOURNAL wishes Dr. Tarumianz success in his new professional venture and wishes to assure him that the medical profession of our little state will stand by.

V. A. CONTRACTS

THE JOURNAL has a supply of the schedule of fees applying to the contract between The Medical Society of Delaware and the Veterans' Administration, reprinted from our January and March issues. Physicians who have signed up for this work and who wish a copy should notify this office.

REGRETS

We regret that in our June issue, in the leading article, the name of the medical college was omitted from the footnote referring to the second author. The reference to W. B. Silberblatt, M. D., should read: Associate in Obstetrics and Genecology, New York Medical College. We regret also a few typographical errors. Corrections will be made in the authors' reprints.

PSYCHIATRIC RESIDENCY

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When a medical student comes out of medical school, the next step he takes to widen his medical knowledge is to apply for an internship in a general hospital. Subsequently, he becomes a resident and after several years, emerges sufficiently armed to meet the exigencies of general practice. Others continue to specialize in some branch or specialty of their own choosing. They become well versed in the abnormalities of the heart, the stomach, and other organs, which make up the whole human organism. They should not stop there. They should remember that a human being, aside from being merely a conglomeration of these organs has the important function of thinking and feeling; and just as he may have a failure in the realm of the physical or the bio-chemical sphere, so can he have a failure in the mental sphere and for that matter, simultaneously both mental and physical. One repeatedly hears of the inseparability of the mind and the body: that any physical disease influences the mind and vice-versa. To cling to the idea of mind-body separation in spite of the recognition of the increasing role that psychiatry is playing in general medicine is to shut one's eyes to the progress of medical science. Consequently, whether one's aim is to become a general practitioner or a pediatrician, or an obstetrician, etc., a thorough knowledge of the fundamentals of psychiatry is a very valuable aid in the intelligent practice of the art of healing; for undoubtedly, a sick man is sick in his entirety and curing a stomach ailment does not cure the stomach condition alone, but the whole individual as well.

It would be difficult indeed to define a background which would meet all of the contingencies of the psychiatric aspects of general practice. Many physicians acquire facility in dealing with the mental aspects of somatic disease while with others, this faculty seems to be a native endowment. A more detailed understanding of psychiatry necessarily entails a greater concentration of study in frank psychiatric conditions and the material for such study is best found in the mental hospital.

Resident training in a mental hospital, besides offering vast educational opportunities, at the same time familiarizes one in the atmosphere of the mentally sick, consequently dispelling that uneasy feeling one may experience during his first visit to a mental hospital.

With reference to the educational side, this is particularly centered in determining the etiology, the diagnosis and differential diagnosis, and the prognosis of the different kinds of mental diseases; in the therapeutic procedures; and lastly, in the correct management of mental patients. The therapeutic aspect will not be of as much concern to the general practitioner as it will be to the one aiming to be a psychiartist. Whatever future psychiatric problems might beset the general practitioner or the specialist, they will call forth, primarily, his knowledge of psychiatric diagnosis and patient management.

The application of the knowledge of psychiatric diagnosis and patient management can be well illustrated in the following situations that may arise in general and specialized medical practice:

(a) In the detection and recognition of an incipient mental illness. The early recognition of a psychiatric problem, as in any somatic disease, influences the course of treatment and the prognosis of that disease. Chronicity is just as real and difficult a problem to handle in mental conditions as in physical conditions. Its implications are even more far reaching for

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the chronic mental patient is truly disabled in his totality. Improper management of the acute phase of a mental illness may often be a major contributing factor to chronicity.

(b) In the intelligent management of certain types of mental states resulting from or occurring with toxic, infectious, or degenerative diseases. Such conditions are likely to be very confusing to the physician particularly from a standpoint of prognosis. The condition may be brief, in which case commitment in a mental hospital would be advisable. The treatment of such cases is purely somatic and can be accomplished in a relatively short period of time.

(c) For a more complete evaluation of the subjective symptoms presented by the physically sick individual. The inherent constitution of the patient has much to do with the subjective recognition of the abnormal symptoms within him. Some patients perceive these symptoms clearly, others, not at all. When a patient is either unable or unwilling to aid the physician dealing with his case, the physician is thrown back upon his own resources and a certain amount of psychiatric experience is indispensable.

(d) For the correct management of the acutely occurring mental states during the period that hospitalization is in the process of arrangement. Thus, anticipating a probable suicidal attempt in a depressed patient, antisuicidal measures may be prescribed. In the same manner, an acutely manic individual may be properly and effectively sedated and managed.

(e) In the recognition of those cases which necessitate referral to a psychiarist. While many fringe psychiatric problems are well within the province of the general practitioner from the standpoint of management, major or total psychiatric conditions definitely require ministration by a psychiatric specialist of long training and experience. The differentiation of serious conditions from those which are more benign is not always easy and it is particularly difficult for one who has had only a theoretical knowledge of psychiatry. Such a differentiation is a problem very frequently encountered, however, and it is in the interest of the general practitioner to gain a minimal necessary orientation in psychiatry to enable him to make the differentiation.

In conclusion, it must be understood that by no means will a year or two of psychiatric resident training build up a specialist in psychiatry. The vastness of this field demands a longer, more extensive and intensive study and training. The principal issue, however, is to gain a working knowledge of the most important psychiatric problems which will lead to professional broadening, to the creation of a harmonious professional coordination among all medical men which ultimately will result in helping elevate the state of mental health in a community.

CONSTITUTIONAL STUDY

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The following cases presented concern a brother and his sister who were admitted to the Delaware State Hospital for treatment of a depressive psychosis. Aside from the existence of the same psychiatric problem, both are suffering from Diabetes Mellitus. The presentation of these cases may have some bearing on the study of the constitutional aspect of the involutional type of psychosis.

LIFE HISTORY

The patients come from a medium sized family of French-American descent. Their parents are both dead. The father, a blacksmith, died of coronary thrombosis at the age of seventy-five and the mother of a brain abscess at the age of seventy-two. There were five children in the family. One sister died in diabetic coma at the age of fifty-three and a brother died after an attack of influenza.

The brother, who is the elder of the two, passed an uneventful childhood life. At the age of sixteen, he finished the seventh grade and on his father's advice, he worked on a farm in Maryland. He was predominantly extroverted, enjoyed to be with his friends to whom he showed much generosity for which reason he was well liked. World events held more than the ordinary interest for him. He enjoyed the radio and the races. Beside being an excessive smoker, he drank moderately, but only infrequently did he overdrink. He belongs to the Roman Catholic Church, but had never been a devout member.

It was at the age of forty-two that he thought of marrying a widow, but they lived

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together only for four years. They had to separate after frequent marital discords. For thirty-two years he had been steadily employed as a laborer in a leather factory.

His sister, who was three years younger than he, entered the public school at the age of six. She was an average student. After reaching the sixth grade, she stayed home with her parents and helped in general housework. She lived with them until they died. Then she went to live and keep house for her brother. She was the shy, quiet, and retiring type. Although she was congenial and friendly to everyone, she never cultivated continued social contacts with any one of her friends. She preferred to spend her time in the flower garden rather than attending an occasional movie, party or games. She had shown no interest for the opposite sex. Her love seemed to have been lavished on her only living brother.

ONSET OF PSYCHOSIS

In December 1943, while convalescing from influenza, the sister experienced vague gastrointestinal discomforts and was found to be suffering from diabetes mellitus. She developed the idea that she was not ever going to recover from this disease. Gradually, she became increasingly depressed and thought herself to be utterly worthless. While in the hospital, she made an attempt to jump out of the window. Several suicidal threats were also made when she was back in her home. Since she continued to be in a despondant state, her brother found her very difficult to live with. Her appetite was very poor and at every mealtime, she had to be coaxed to take a mouthful of food. At night she slept very poorly and went for days without a bath or change of clothes. She refused to see anybody and she lost interest in everyday occurrences. Frequently she would be pacing the floor continuously, biting her fingernails and wringing her hands. She followed her brother around the house remarking, "What are you going to do with me? Where are you going to put me?" Her brother was compelled to take the precautionary measure of locking her up in the house before leaving for his work. For four months she continued this pattern of behaviour until she was admitted to this hospital on April 3, 1944.

During her hospitalization, her brother managed fairly well to live by himself. He visited her at the hospital frequently and faithfully for four years. Suddenly on February 1, 1948, he went into coma, diagnosed to be diabetic in origin. After two weeks in the hospital he was recovered sufficiently to resume his former work. Days later a cousin of his, paid him a visit and noticed that he looked very listless and worried. He expressed no desire to resume work complaining that he was "down in the dumps and done for." He continued to be depressed and moody. One day, while at work, he attempted to kill himself by jumping into the fly-wheel of a factory engine, then became aggressive, threatened his boss with a knife and tried to cut his own wrist. The help of the police was needed to take him to the hospital.

CLINICAL STUDIES

Status on Admission. His sister was fifty-six years old when she entered the hospital in a markedly depressed state. She seemed passive and listless and stared into space. Retarded and lacking in initiative, she only spoke when talked to. She kept repeating that she had done something "terrible" for which she could never be forgiven. Repeatedly she was talking of killing herself.

She showed endoectomorphic physical characteristics with well developed muscles, soft lines, a short thick neck, and a somewhat rectangular face. All her fingernails were badly bitten, only the rudiments remaining, and the cuticles were excoriated. Past medical history revealed a cholecystectomy. She had passed through menopause with no severe physical symptoms. Laboratory studies revealed diabetes mellitus.

Her brother entered the hospital four years later in a similar state of despair and dejection. His appearance was disheveled and his general attitude, one of hopelessness. During conversations, he became agitated. Life, he thought, was no longer worth living and death seemed a welcome relief. He constantly threatened to commit suicide.

Physical examination revealed an endoectomorphic physique. Most of his fingernails were bitten off. Laboratory studies disclosed diabetes mellitus and chronic nephritis.

Progress. His sister after several days of observation did not reveal any amelioration of her depressed and agitated state. It was de-

cided to begin a course of electro-convulsive therapy. At first there was a marked mental improvement noticeable. This improvement, however, was of a temporary nature. She soon relapsed into a state of agitated depression, moaned and groaned continuously, kept wringing her hands in despair and hopelessness. Very frequently she was negativistic and contrary, refusing nourishment. Various therapeutic approaches varying from psychotherapy under sodium amytal to resumption of electro-convulsive therapy have failed to influence the depressive state up to this time. The diabetes is however well controlled clinically.

Her brother, after several days of observation following his admission, showing no visible improvement in his condition, was placed on electro-convulsive therapy. After the first few treatments, he was more active and alert and his appetite improved, although there was still some degree of restlessness and preoccupation. With several more treaments, he showed a complete change of mood. He became overcheerful and exuberant and remained somewhat hypomanic for several days. Shock treatments were discontinued and psychotherapeutic sessions began. Patient regained a rational outlook and showed initiative and interest. The diabetes was brought under control and the nutritional state improved. He is still under observation in the hospital. Occasionally, mild fluctuations of mood can be observed, but depressive phases have not been severe.

CONCLUSION

Some constitutional aspects of involutionary depressions are presented in this case study of brother and sister, both suffering from similar types of psychoses as well as diabetes mellitus. The clinical picture during the initial period of observation showed some striking similarity, whereas the subsequent course differed a great deal. The family background, the life histories of the observed patients and the clinical studies bring out some indications of the biological basis of involutionary psychoses.

ALDARSONE THERAPY IN THE TREATMENT OF GENERAL PARESIS

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The advent of penicillin therapy in the treatment of General Paresis (syphilitic meningo-encephalitis) has swung the direction of thought away from the pentavalent arsenical compounds. Several investigators (1), (2) have raised the question of discontinuing the use of these drugs in view of the more effective results with penicillin. It would seem advisable, therefore, to determine the therapeutic effectiveness of the pentavalent drugs, tryparsamide and aldarsone, so that a baseline for comparison with penicillin could be established.

Stokes (3) has reported the average clinical remission rate with tryparsamide to be 22.5% in advanced cases of General Paresis and 49.7% in early cases of this disease. Kamman (4), Spiegel (5), Bennett (6) and Sexton (7) have reported favorable results with aldarsone on small numbers of General Pareties, but in none of these reports has the period of follow-up or the number of cases studied been sufficient to draw any final conclusions similar to those made by Stokes for tryparsamide. This paper is a report of treatment results with aldarsone therapy over a five year period at the Delaware State Hospital, Farnhurst, Delaware.

MATERIAL

Of a group of sixty cases admitted to the Delaware State Hospital in 1942 and 1943 with intermediate and severe General Paresis, that is, those who showed psychiatric syndromes with moderate or advanced deterioration, thirty-nine received aldarsone, mapharsen, and bismuth as their sole treatment over a period of five years. It was felt, therefore, that this group reflected well the effectiveness of aldarsone in this stage of central nervous system syphilis.

CRITERIA OF ADEQUATE TREATMENT

It seemed important to determine how many of the thirty-nine cases studied received adequate chemotherapy during the five-year period in evaluating the effectiveness of the

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drug. Using the scheme set forth by Stokes (3) as a guide, an adequate schedule for one year appeared to be one following approximately the following formula:

Bismuth subsalicylate — 12 injections (1½cc), one, twice weekly for 6 weeks

Aldarsone —14 injections (lgm.) weekly intervals (except first week 0.5 gm.)

Mapharsen—14 injections (lgm.) weekly intervals

Bisumth subsalicylate — 14 injections (2cc) weekly, first two given with last two Mapharsen injections

Rest period 4 weeks and repeat unit.

Using such a criteria all cases but two received adequate aldarsone therapy. However, seventeen of the thirty-nine cases (44%) had received inadequate mapharsen therapy. Of this latter group four had suffered relapse during five year period following an initial clinical remission with partial reversal of spinal fluid formula. This would raise the question of the importance of mapharsen in maintaining therapeutic remission inasmuch as these cases all received aldarsone on weekly intervals rather than the mapharsen-bismuth schedule suggested above.

ADJUSTMENT CATEGORIES

Clinical results of therapy were divided into categories of adjustment suggested by the Committee of Non-Specific Therapy of Syphilis (8) as follows:

Remission: Sufficient clinical recovery to permit patient to return to his former socio-economic status.

Improved: Complete or partial disappearance of clinical manifestations without corresponding improvement in capacity to return to former socio-economic status.

Unimproved: No detectable clinical evidence of change in course of disease. Those who showed progression of pathology also put in this group.

Death: Treatment deaths during therapy or regardless of cause occurring during or within three months subsequent to therapy.

SPINAL FLUID CATEGORIES

Yearly spinal fluid examinations of cells, serology and colloidal gold curves were available over the five-year follow-up period. Each case was evaluated and placed in one of the three possible categories (approximately) of spinal fluid formula reversal: (A) Little or no reversal, (B). Partial reversal, or (C). Complete reversal. Using the above adjustment categories and spinal fluid categories, a table of clinical findings was made up as illustrated below:

TABLE OF CLINICAL FINDINGS

Spinal Fluid Formulas

Adjustment Categories	Little Reversal	Partial Reversal	Complete Reversal	Total
Remission	3	3	4	10 or 26%
Improved	3	1	1	5 or 12%
Unimproved	6	6	2	14 or 36%
Death	7	3	0	10 or 26%

COMPLICATIONS

Much has been written about the comparative toxicity of tryparsamide and aldarsone. Careful examination of the records of the ten patients who succumbed during or following aldarsone therapy revealed that two were admitted to the hospital *in extremis* and died within two weeks of the admission date; six died of progressive pathological deterioration without reversal of spinal fluid and with no evidence of drug toxicity at post mortem; one died of unexplained cause; and one died in cardiac decompensation from what appeared to be chronic toxicity of drug in view of a normal EKG eight months prior to death. No post mortem was done on this case, however, to confine the clinical impression.

All thirty-nine cases were checked periodically for signs of optic atrophy by ophthalmologists. In no case was it observed among this group. One case showed vomiting following aldarsone and mapharsen injections which was controlled by pre-treatment administration of belladonna and elixir of phenobarbital.

CONCLUSIONS

1. Thirty-nine cases of General Paresis were treated with what appeared to be adequate aldarsone therapy, along with auxilliary mapharsen and bismuth over a five-year period.

2. Ten cases (26%) showed a clinical remission, and 5 cases (12%) showed improvement.

3. Four cases had shown an earlier remission but relapsed later in course of persistent aldarsone but inadequate mapharsen and bismuth therapy which suggested importance of

these drugs in maintaining therapeutic remission.

4. Careful examination of cases dying during or following therapy indicated only one might have died as a result of chronic arsenical therapy. No cases of optic atrophy were observed nor were other severe complications evident.

5. Aldarsone appears to be about as effective as tryparsamide in producing clinical remissions in advanced cases of General Paresis.

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A STUDY OF NURSE AND POLICE APPLICANTS

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Psychologists of the Delaware State Hospital and Mental Hygiene Clinics have been examining young women who apply for admission to hospital nursing schools and young men who apply for positions in the state and city police departments for some time. A summary of the test results is regarded of interest. Questions proposed for consideration are: What is the personality pattern of the candidates for these services? What are the candidates' vocational interests? Are the aspirants feminine or masculine in their outlook?

Subjects:

Sixty young women, mainly Delawareans, formed the nurse group. They varied in age from 16 to 19 years inclusive. The average girl was 18 years old. Most of the candidates had completed senior high school by the time of the examination.

Forty applicants for state and Wilmington police positions constituted the police group. They ranged in age from 20 to 25 years inclusive; the average man was 23 years old. Five months of the senior year of high school was the usual educational achievement, although schooling varied from completion of the ninth grade to completion of the first year of college.

The subjects were selected in regard to age, with younger applicants given preference. It was thought perhaps they might have truer aspirations for the vocations than their older associates; the latter may have shifted to the field for reasons other than a "yearning to be one". Selection of subjects also was made to include as many as possible of those given the Kuder Preference Record (1). The Record has been used uniformly in this test battery only during the past two years.

Methods

The objective method of personality analysis devised by Jastak was used to determine the normality of intelligence and measurable character factors. His analysis permits the assessment of five personality traits, namely native capacity, language polarity, reality contacts, motivation and psychomotor efficiency. *Native capacity* or intelligence is defined as the level of maximum personality integration. *Language polarity* weighs verbal ability; *reality contacts* measures how well one can see things as they are; *motivation* expresses perseverance, drive, self-control, self-discipline and responsible behavior in general; *psychomotor efficiency* denotes muscular coordination or the adequacy with which parts of the body are put together and function as a smooth-running unit. The calculation and further interpretation of these personality traits have been discussed by Jastak and Vik (2).

Vocational interests of the individuals studied were obtained by means of the Kuder Preference Record. The Record provides nine scales of occupational interest on which an individual chooses those activities which he likes most to engage in and those which he likes least. These nine scales are mechanical, computational, scientific, persuasive or commercial, artistic, literary, musical, social service, and clerical.

As a by-product of the Kuder test, the masculinity-femininity score (M-F score) for each nurse and police applicant was determined according to the method outlined by Kuder (1). The weights assigned to the raw scores of each scale for high school students were used in case of the nurse group and weights for adults in the case of police. High positive scores indicate masculine preferences and outlook. Low

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positive and negative scores represent feminine preferences and views.

Results and Discussion:

Applying Jastak's technique of personality analysis to the test results of the candidates, it was found that the average nurse and police applicant have high average native intelligence and normal character traits. While the average for each group is normal, there are individual members who show abnormal personalities. For example, one-third of the nurses display poor perceptions of reality. These girls will tend to misinterpret daily situations in the sickroom, will not be sufficiently observant of the patients' needs, will lack alertness in the event of an emergency, will fail to take the initiative when the occasion demands, and in general be governed by impractical judgments.

One-fourth of the police group rates poorly in psychomotor efficiency. Such men tend to be clumsy. They will not be sufficiently agile nor fleet-footed to aid citizens in distress or to apprehend escaping criminals skillfully.

Average percentiles on the nine Kuder scales show outstanding vocational interests for nurses in only two fields, namely scientific and social service. This result is confirmed by a comparison of the nurse mean raw scores on the nine scales with those of Kuder's base group of women. Very significant positive interests appear in the social service and scientific fields and very significant negative interests in the mechanical, artistic, persuasive, clerical, literary, and possibly computational areas. These differences are significant at least at the 1% level, i.e., there is only 1 chance in 100 that the difference could be due to chance. Therefore nurses in general are interested primarily in working with and serving people and using scientific knowledge to that end. Most of them would not make good clerks, lawyers, machine operators nor journalists.

The average percentiles on the nine Kuder scales for the police present only one outstanding vocational interest, that is, social service. This finding is confirmed by a comparison of the police mean raw scores on the nine scales with those of Kuder's base group of men. Very significant positive interests are seen in the social service area and probably in the musical field; and very significant negative interests occur in the computational and clerical vocations. These differences are all significant at least at the 1% level. Therefore police applicants are interested primarily in working with people. Most of them are not mathematicians nor fitted to be clerks.

The mean M-F score 6 and standard deviation of the M-F distribution 19 for the nurses indicate femininity. The middle two-thirds of the group have M-F scores lying between —13 and 25 which is at the extreme feminine end of the scale.

The mean M-F score 71 and standard deviation of the M-F distribution 23 for the police represent masculinity. The middle two-thirds of the group have M-F scores between 48 and 94 . The lowest score 27 is somewhat higher than that of women selected at random from many occupations as given by Kuder.

According to the results above, the nurses are distinctly feminine and the police are definitely masculine. Additional evidence for these findings is seen in a comparison of the mean M-F scores of nurse and police groups. The ratio of the difference of the two means to the standard error of the difference is extremely significant and shows that nurses and police are well-differentiated by this technique.

CONCLUSIONS

1. In general, nurse and police applicants have high average native intelligence and normal personalities. But some individuals in the groups suffer from handicapping character weaknesses which make them poor candidates for the services in question.

2. Nurses are interested primarily in working with and serving people and using scientific knowledge to that end. Police mainly aspire to work with people in some capacity.

3. Nurses are definitely feminine and police distinctly masculine in outlook and interests.

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SOCIAL NEGLECT: A STUDY OF TWO FAMILIES

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The records of two families were chosen to point up social neglect. (Necessary medical care was given.) One family had been considered a "public nusiance" for 35 years before referral to the Mental Hygiene Clinic in 1932, and after that examination the family has continued to be a "public nuisance" to date. Both families fall in a category which seems to be no agency's responsibility. They are not eligible for or do not need public assistance, or foster home placement, and are not under the supervision of any state institution's social service department. The community asks over and over why nothing is done. The Mental Hygiene Clinic is an organization without authority, and can only advise.

On examination in the Clinic we often find people with inadequate personalities and people of limited intelligence that we feel should be able to make a satisfactory social adjustment in the community if adequate supervision is given. Some should be given a trial in wage homes before institutionalization is recommended, as in the case of Elsa and Charles M. In the case of Maud X, who did not adjust in the community, commitment to a state school for mental defectives should have been carried out after the trial.

There is no over-all state agency to do case work with families who present serious social problems. There is only one private family agency serving New Castle County, and no such agency for the two other counties. In order to obtain such supervision the communities and the state must recognize the need for some agency whose functions are broad enough to include this type of service, whether or not financial assistance is needed. The agency must accept the families as its continuing responsibility and call in the services of specialists, including such agencies as Mental Hygiene Clinic when indicated, but continue their relationship with the family and assist them or the community in carrying out recommendations made. This demand by the community is the first step necessary in improving social conditions. One must keep in mind what these two families must have cost the state and local communities because of the lack of t his type of supervision.

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CASE I—THE X FAMILY

This case was referred to the Mental Hygiene Clinic in 1931, at which time the family lived in a one-room log cabin two miles from a town. Several citizens from the town described them as "backwoods characters, poorly dressed, unshaven, undernourished, and looking defective." The community considered this family wholly incapable and unreliable. They have begged in various localities in that section and had been a neighborhood problem wherever they lived for the past 35 years. Last year, when one of the children died, the only furnishings in the home were an old cook stove, a box, and straw mats on the floor. Another citizen volunteered the information that this family "are all fit subjects for Delaware Colony. They are weak-minded and have always been liars, beggars and a general nuisance in any neighborhood where they have lived."

The father, aged 53, "has just sense enough to go in out of the rain if it is raining hard enough." "If you put him to work, as soon as you are out of sight he disappears or gets a pain." The mother, aged 54, has been known to informants since she was 18 years of age.

There are 3 children by this union: Edgar, aged 32; Maud, aged 21, married and having 2 children, and Harry, aged 18. One child died of "neglect" last year. At one time Edgar was considered a "menace" to his sister, and was terrorizing young girls in the neighborhood.

Our records do not give any reason why the father was not examined at the Mental Hygiene Clinic. When the mother was again referred to our Clinic in 1938, we learned the father was in jail at the time serving a 5-months sentence for stealing corn. After this he continued to be a worthless member of various communities until his death in 1946. His funeral expenses have never been paid, though the family promised to pay two dollars a week.

The mother was examined at the Mental Hygiene Clinic March 4, 1932 and found to be feebleminded. Commitment to Delaware Colony was recommended but she was not ac-

cepted by the superintendent, according to our records, because she was beyond the age limit for admission.

In January 1938, the mother was again referred for examination, while she was in jail on a disorderly conduct charge. Social investigation revealed the following:

The neighbors live in fear of her. They have never seen her pleasant or happy. It was reported that she both stole and begged and several times had sold the same pig to several different persons and would frequently offer to "work out" some gift, but after a half hour of work would leave, swearing. She claimed to be able to out-work any man in the field and men agree that she can. Last summer she went barefooted, wearing a winter flannelet nightgown with no underclothing, on all her excursions. Her reputation for stealing and begging dates back many years. Recently she threatened to cut a man's throat from ear to ear and threw a butcher knife at her son-in-law, which missed him and stuck in the wall. She beat her daughter with a broom and rolling pin.

She often took her grandchildren, Paul, 6 years, and Lottie, age 3 years, on long walks supposedly keeping them in the woods at night. In winter she took them for a very long walk, though they had whooping cough at the time. They were wet and cold when they returned and one returned barefooted, though he wore shoes, stockings and overshoes when he left home. The children have been very ill since this walk. It was because of this incident that her son-in-law swore out a warrant for her arrest on a disorderly conduct charge. A psychiatric examination at this time showed her to be mentally defective with strong paranoid trends, and of an emotionally unstable personality.

She was released from jail a short time after this and has continued to be a "nuisance" in various communities. In May, 1948, she was still going around town drawing a little express wagon in which she puts anything she can collect, such as scraps of wood for kindling or any food or clothing she can beg. She is frequently barefooted. She asks for medical care and favors from town officials without any thought of payment or even a "thank you." The same is true of the rest of the family. No one knows just how they are able to get along by doing so little work. One farmer says that when any of the family works for him he has to get the worker out of bed in the morning and take him home in the afternoon. They can do only simple work.

The daughter, Maud, had a sterilization operation performed in 1934. The Clinic felt that the parents would never consent to commitment of the children, and if sterilized they might make an "adjustment of sorts." Maud and her husband received relief for a very short period in 1938 and this was discontinued because of "misrepresentation." About this time she and her husband were asked to move because he was doing so little work and she was becoming "sexually aggressive." Both had a venereal infection. Their two children were re-examined after they recovered from whooping cough and both found to be feebleminded. They were committed to Delaware Colony within the next year, where they are now. One of Maud's paramours is requesting Lottie's parole.

CASE II—THE M FAMILY

The M. family was first known to the Mental Hygiene Clinic in December, 1939. Mrs. M. was referred by the County Health Officer for sterilization. He stated "home conditions are very, very poor, six children, two dead, mother doesn't know ages of children, and seems incapable of care of family and baby who is suffering from neglect. All children appear retarded."

When the social worker visited she found the home filthy, old blankets were hung at the windows, there was a foul odor inside and a state nurse told the worker that when she called a week after the baby's birth, mother and baby were lying on a filthy mattress which smelled of urine, and she did not think any new baby could get as dirty in one week.

Mrs. M. could not remember dates of birth of any of her children and referred all questions to her oldest daughter; she did not even remember her father's name or anything concerning him. She talked in short- choppy sentences and gave the impression of being incapable of caring for her family. She has been living in common-law relationship with Mr. M. since she was 17 years of age. She is believed to be 37 years old at this time.

On examination she was found to be inherently defective and functioning at the imbecile level. The psychiatrist found her incapable of caring for her children and since he felt both she and her husband would oppose commitment to Delaware Colony, he recommended sterilization.

Four of the children were examined at this time. Charles, age 7, was found to be defective, to have a specific language handicap and be unable to profit from first grade work. Elsa, age 10½, had learned practically nothing at school, and was found to be mentally defective. Beth, age 13, was possibly of borderline intelligence, and Grace, age 16, was ineffectual in situations requiring planning ability, and defective at the high moron level.

Charles, Elsa and Grace were recommended for commitment to Delaware Colony if home conditions continued to be unsatisfactory. This report was sent to the State Board of Charities but was returned as the case was "not active" with them, so there was no social worker to carry out these recommendations.

A few months later, Elmer, age 1½, was examined and the psychologist felt he had average potentialities but appeared very neglected in language development. John, age 5½, examined at this time was found to be retarded in all mental functions but considered to be only functionally defective and potentially higher in native endowment. Foster home placement was recommended since it appears unlikely the home environment can be greatly improved. If this should fail to bring about the hopeful result, commitment to Delaware Colony might be considered later. Again there was no social agency active, and he was never accepted for foster home placement.

Mr. M. was referred for examination by the Relief Unit in 1940 because of complaints of headaches and being overheated in the sun so that "a spot came up on my head." Physical examination at the time revealed dental caries and moderately increased blood pressure. He was found not to be defective, but due to general neglect, lack of schooling and a very inferior environment, he functions at the borderline level of adjustment or below. It was recommended that he be studied physically because of his moderately increased blood pressure. He was seen again about a year later, at which time he reported he was feeling better. Home conditions remained the same or worse and no social agency was active until the County Health Unit and Visiting Teacher referred the family to the State Board of Welfare in August, 1945, for protective work because of the neglect of the children. They brought the case to the Juvenile Court, which organization referred the whole family to the Mental Hygiene Clinic for examination in May, 1946.

In the interval between examinations Mrs. M. had had two more children as the recommendation for sterilization had not been carried out. George, born October 16, 1942, was found to be mentally defective at the moron level. It was felt he would show some improvement with proper training in a school for mental defectives and commitment to Delaware Colony was recommended. Florence, born April 3, 1945, was found to be at the moron level, also in need of medical and nutritional attention and eligible for commitment to Delaware Colony, which was recommended so that she might receive proper care.

These two children are two more potential charges on the state of Delaware because the original recommendation for sterilization of the mother was not carried out. The mother was re-examined and found incapable of giving her children proper care. She was eligible for sterilization study and commitment to Delaware Colony, both of which were recommended.

Elsa was re-examined at this time. Results of the examination showed her still defective at the moron level, and eligible for commitment to Delaware Colony. Because she had shown some ability to assume responsibility for simple tasks in the home, it was suggested she might be tried in a wage home where there was not too much demand upon her mentality. In such an event, however, sterilization should precede this trial to prevent the continuance of this family strain. Trial in a wage home means that she shall remain under the supervision of an agency and be committed to Delaware Colony if this plan does not work.

Charles was re-examined and found to be inherently defective at the moron level and

still displaying a severe language handicap. He is eligible for commitment to Delaware Colony but might adjust in a wage home as a simple laborer, thus saving the state this financial burden. In such an event he should be studied for sterilization to prevent propagation of this defective taint.

Re-examination of John found him mentally defective at the imbecile level, and commitment to Delaware Colony was recommended. He is not trainable under normal circumstances.

Joseph on re-examination was still found mentally defective at the moron level. It was thought he might show some improvement at a school for mental defectives and commitment to Delaware Colony was recommended.

Mr. M., the husband and father of this family, was still found to be an inadequate person, with lack of social drive, many somatic complaints, and alibis for not fulfilling his parental responsibilities.

The only one of the above recommendations carried out was commitment to Delaware Colony of Mrs. M. for sterilization. Commitment of the children was requested of the Court but no action was taken and months later Mr. M. was removed from the family on a charge of murder and no agency remained active, as the Superior Court did not request any assistance nor refer the children back to any social agency for placement or supervision.

Two years later we learn that after the sterilization operation was performed on Mrs. M. she has been paroled to her feebleminded daughter, Grace, who has married and has two children. It is reported Mrs. M., who was found incapable of caring for her own children, is to care for Grace's children while Grace works in a factory. Charles and Joseph are reported to be with her in this home.

Elsa is reported to be married; no information on her adjustment. The same is true concerning Beth, who also is married.

Elmer and Florence are reported to be living with an aunt, and John is living either in this home or with one of his married sisters.

During the period covered in these cases, from 1938 to date, there have been changes in organization and function of some of the agencies in the state. The State Board of Charities and Mothers' Pension Commission are consolidated and known as the State Board of Welfare, which has an assistance program giving aid to dependent children, a foster home program, and does protective work in the two lower counties, which means cases may be referred to them where neglect or cruelty to children is indicated. This organization has no family service and does not work with children beyond their eighteenth birthday. The State Board of Health has only a medical program, the state institutions do not have a social service department large enough to do family case work over a period of years with these families, and the other social agencies active in these two families studied were not equipped to give the necessary supervision, nor did their program include anything but temporary assistance.

These families illustrate the cost of repeated temporary services of various types, treating symptoms rather than causes, and no one organization taking time to study the total situation and then be able to continue work with the families until recommendations were carried out and results accomplished. Physicians like to see their patients remain under treatment until they are cured. Social workers too like to carry through on plans for social action and to see something accomplished, but they cannot carry out recommendations without the assistance of the communities who must first recognize the need for, and then desire, some action.

The tuberculous patient should receive more than one gram of protein per day, and the diet must supply enough calories to balance his energy requirements. The calories supplied by carbohydrates and fats must contribute to the total fuel value, in such a proportion that the calories from fats should not fall below 30% or exceed 40%. If the patient receives a diet adequate in all respects and supplying a sufficient amount of protein, it is very probable that his body will store proteins for his repairing needs, just as would be the case in an ordinary individual. J. D. Adamson, M. D., Canad. Tubere. A. Tr., 1947.

A.B.A. Criticizes Security Mirage

A recent resolution of the House of Delegates of the American Bar Association highlights little known facts about the operation of the fund accumulated under the Social Security Act which is administered by the pro-compulsory health insurance Federal Security Agency.

The resolution reveals: (1) That 99.5 per cent of the funds thus far accumulated under the Act have been spent on public projects, and that special non-negotiable Government obligations have been substituted "for 86.26 per cent thereof." (2) That "such part of such sum as may be necessary to meet extraordinary demands which may arise in the future will of necessity have to be raised by the sale of negotiable bonds or by the imposition of taxes to redeem the non-negotiable obligations."

This means that the money paid into the fund by employers and employees, comprising about 60 per cent of the taxpayers in the United States, has been spent, and that when the fund must be replaced, these same people will pay their share again to reactivate the fund. "Thus," the resolution states, "the working classes of the country which have been and are now employed are taxed doubly."—Amer. Coll. Radiol. *News Letter*, June, 1948.

WANTED BY THE FBI
A NOTE TO PHYSICIANS

Hugo Bob Hubsch, with aliases Robert C. Glass, R. C. Harris, Hogo Hobsch, Louis S. Miller, is being sought by the Federal Bureau of Investigation. On November 7, 1945, a Federal Grand Jury at Jackson, Mississippi, returned an indictment charging this man with a violation of the National Stolen Property Act. He is charged with another violation of the National Stolen Property Act in a complaint filed with a U. S. Commissioner at Birmingham, Alabama, on June 7, 1948. This individual has defrauded numerous physicians and hospitals in Eastern and Southeastern sections of the United States during the past few months through the medium of fraudulent checks.

Investigation has revealed that Hubsch has a chronic kidney ailment and it has recently been ascertained that he has a large kidney stone in the right ureter about four inches below the kidney. This condition has caused local inflammation which, at varying intervals, results in almost unbearable pain. He has been advised that it would be necessary for him to undergo major surgery for the removal of the stone in the near future and until that surgery is performed he will need frequent, if not continuous, medical attention. This fugitive moves about rapidly in that section of the United States which is East of the Mississippi River and recently he has given numerous physicians and hospitals fraudulent checks in return for treatment, hospitalization, sedatives and narcotic prescriptions.

The following is a complete description of Hugo Bob Hubsch: Age, about 52, claims to have been born in Budapest, Hungary, November 4, 1895; height, about 5 feet, 6 inches; weight, 140 to 170 pounds; hair, dark brown, graying; eyes, brown; build, medium; race, white; nationality, believed to be naturalized American; occupations, laborer, pharmacist; scars and marks, left arm partially paralyzed, needle scars on both arms, large scars above each hip resulting from kidney operations, shrapnel scars and two bullet scars on abdomen, bridge in upper front teeth; characteristics, long nose, stooped posture.

Anyone having information concerning the whereabouts of this fugitive should immediately notify the nearest office of the Federal Bureau of Investigation or your local law enforcement agency.

OBITUARY

FRANK G. LOCKWOOD, M. D.

Dr. Frank Goldsmith Lockwood died suddenly on March, 1948, as the result of a brain tumor.

Dr. Lockwood was born at Hannibal, New York, on July 11, 1914, the son of the late Professor Stephen Roy Lockwood and Mariette Harris Lockwood. He graduated from Hannibal High School in 1933, and received the degree of Bachelor of Arts in 1938, and degree of Doctor of Medicine from the University of Buffalo in 1942. He served an internship and residency at the Henry Ford Hospital at

Detroit, and in 1945, became the Medical Director of the du Pont Company's plant at Buffalo. In April, 1946, he was transferred to the Chambers Works at Deepwater, New Jersey, and in February, 1947, was again transferred to the plant at Edge Moor, Delaware.

Dr. Lockwood was a diplomate of the National Board of Medical Examiners, and was a member of the New Castle Medical Society, the Medical Society of Delaware, and the American Medical Association.

He is survived by his wife, the former Lillie H. Tonden, his mother, Mrs. Mariette H. Lockwood, of North Hannibal, New York, and four brothers, Maurice G. Lockwood of North Hannibal, New York; Robert R. Lockwood of Arlington Heights, Illinois; Harris C. Lockwood of Silver Spring, Maryland, and his fraternal twin, Fred S. Lockwood of Arlington Heights, Illinois.

The funeral was held March 12, 1948, in the Newkirk Funeral Home at Salem, New Jersey, and burial was in the Baptist Cemetery at Salem, New Jersey.

MRS. MILDRED HUTTON TOMLINSON

Mrs. Mildred Hutton Tomlinson, widely known in civic as well as political circles, died in Wilmington on July 23, 1948. Mrs. Tomlinson had been in failing health for about six months. She was 64 years old.

She was born in Louisville, Ky., daughter of the late Dr. and Mrs. W. H. H. Hutton. She came to Wilmington in October, 1916, after her marriage to Dr. Robert W. Tomlinson.

Mrs. Tomlinson was active in the organization of the Woman's Auxiliary of the Medical Society of Delaware, served as president of the state auxiliary, and later was elected National President of the Woman's Auxiliary of the American Medical Association. She also served as a member of the board of directors of the national organization.

She also served as president of the Wilmington City Federation of Women's Clubs and Allied Organizations.

For some years she was active in the Girls' Friendly Society of Old Swedes Church, although she was a member of Trinity Episcopal Church.

She was elected to the vice-chairmanship of the Republican City Committee in 1934 and had served continuously since that time. She was appointed a clerk in the Register of Wills office in March, 1942, but recently had been on leave of absence because of ill health.

Surviving are her husband, Dr. Tomlinson, who now resides in Wilkes-Barre, Pa., two daughters, Mrs. Natalie B. Bradford of Wilmington, Mrs. Virginia T. Stokes of Fort Wayne, Ind., four grandchildren and a sister, Mrs. Thomas MacKellar of Wellesley, Mass.

Funeral services were held in Old Swedes Church on July 26, and burial was in St. George's Chapel Cemetery, at Dagsboro, Del.

BOOK REVIEW

Treatment of Heart Disease. By William A. Brams, M. D., Associate Professor of Medicine, Northwestern University Medical School. Pp. 195, with 11 figures. Cloth. Price, $3.50. Philadelphia: W. B. Saunders Company, 1948.

This short, concise book on treatment of heart disease admirably fulfills the purpose of the author in giving general practitioners and medical students a systematic and practicable guide, without the confusion of detailed theoretical discussion and without detailed mention of questionable or unproven methods of therapy. It is readable and very well presented. The description of the pharmacologic action of various drugs used in cardiac cases, with the clinical application of each, is the basis of the book. The conclusion as to the efficiency of strophanthin K shows the value of long, carefully controlled clinical experience. The treatment given for congestive failure is excellent.

In discussing the treatment of certain special conditions, the advice given is not so fortunate. In cardiac-aortic syphilis, for instance, penicillin is perhaps not given a sufficiently important place in therapy. Likewise, in thyrotoxicosis the very dangerous treatment advocated is Lugol's solution daily for apparently indefinite periods of time. Certainly propylthiouracil is preferable as a routine procedure. Again, it is questionable whether, in the presence of heart disease, thyroid extract should be given to patients with obesity.

Such criticisms, however, are minor. The book should serve a very useful purpose. It is practical and timely.

1789—MEDICAL SOCIETY OF DELAWARE—1948

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1948